

Auburn Montgomery Student Health Services

7461 East Dr
Montgomery AL, 36117-8092
(334) 244-3281

Date: 11/03/21

PATIENT: WILDMAN, LAURA **DOB:** 08/13/1985 **Gender:** FEMALE **MRN:** 5066 **AGE:** 36 Years

VISIT TYPE: Office Visit New

CHIEF COMPLAINT: Right eye draining

HISTORY OF PRESENT ILLNESS: Mrs. Wildeman is a 36 yo female here today for right eye irritation, redness, and watery drainage that began yesterday afternoon. She wears contacts. She reports that bright lights hurt her eye. But no pain. She is only wearing her left contact presently.

VITALS: BP: 137/81 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 75; **Temp:** 97.9; **Resp:** 16; **Ht:** 66 in.; **Wt:** 134.4 lbs.;
BMI: 21.69; **Pulse Oximetry:** 99%; **FDLMP:** 10/07/21

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: Denies

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Married. Works on campus. Has 1 child. Drinks alcohol weekly. Denies smoking or illicit drug use.

FAMILY HISTORY:

REVIEW OF SYSTEMS:

CONSTITUTIONALS: All 14 point review of systems negative except those listed in HPI.

PHYSICAL EXAMINATION:

GENERAL: GENERAL: No apparent distress noted; Well developed; Pleasant.

HEENT: Head- normocephalic; atraumatic. Left Eye- sclera white, conjunctiva pink, EOMI. Right eye- sclera and conjunctiva erythematous with moderate amount of watery drainage present. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; No maxillary or frontal sinus tenderness. Throat- pink without exudates. No anterior or posterior cervical nodes palpated; No palpable thyroid abnormality or enlargement.

CARDIOVASCULAR: S1 S2; Regular rate and rhythm; No systolic ejection murmurs noted; No carotid bruits noted. No peripheral edema bilateral lower extremities.

RESPIRATORY: Breath sounds equal and unlabored. Clear to auscultation bilaterally without wheezes, rales, or rhonchi.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

MUSCULOSKELETAL: Normal range of movement x 4 extremities; 2+ DP and PT pulses bilaterally

INTEGUMENTARY: Warm, dry, intact. No lesions or rash noted.

NEUROLOGIC: Alert and Oriented X3. CN II-XII intact. Sensation intact. Speech clear. Ambulates with steady gait.

PSYCHIATRIC: Appropriate mood and affect.

OFFICE PROCEDURE(S):

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Procedure 1: Eye exam w/ wood's lamp and stain

Right eye numbed with 2 gtts of proparacaine 0.5% oph. Stained with flourascein strip. No foreign body or corneal abrasion noted on exam.

ORDERS:

Visual Acuity (1 unit(s)): Office Procedure

RESULTS:

Visual Acuity:

Right Uncorrected: 20/200

Left Corrected: 20/13

ASSESSMENT:

B30.9 - VIRAL CONJUNCTIVITIS, UNSPECIFIED (PRIMARY)

PLAN:

Pataday Once Daily Relief 0.2 % eye drops

Refills: 0 Qty: 1 BOTTLE(S)

Instructions: INSTILL 1 DROP INTO AFFECTED EYE(S) BY OPHTHALMIC ROUTE ONCE DAILY

She was advised to stay out of work until the redness and drainage subside due to risk for spread to others as she works in a daycare facility. Handwashing. Follow up with ophthalmologist/optometrist for worsening symptoms. She was informed that symptoms may get worse for the next 3-5 days and that is to be expected with viral conjunctivitis. No contacts until symptoms resolve and throw out the current pair of contacts and the container. She verbalized understanding.

Electronically signed by Lindsey Barton, CRNP on 11/03/21 3:57 PM

A handwritten signature in blue ink that reads "J. Barton, CRNP". The signature is written in a cursive, flowing style.